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No. 99-0830

Supreme Court, U.S.
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In The
SUPREME COURT OF THE UNITED STATES

DONALD STENBERG,
Petitioner,

v.

LEROY CARHART,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

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MOTION FOR LEAVE TO FILE BRIEF AND BRIEF *AMICUS CURIAE* OF THE RUTHERFORD INSTITUTE IN SUPPORT OF PETITIONER

John W. Whitehead
Steven H. Aden
Maria E. Selig
THE RUTHERFORD INSTITUTE
1445 East Rio Road
Charlottesville, Virginia
22901
(804) 978-3888

Thomas W. Strahan
(Counsel of Record)
3740 Edmund Blvd.
Minneapolis, Minnesota
55406
(612) 729-6765

February 23, 2000

QUESTIONS PRESENTED FOR REVIEW

1. Whether the Eighth Circuit's adoption of a broad unconstitutional reading of Nebraska's ban on partial-birth abortion, which directly conflicts with the narrower constitutional construction of similar statutes by the Seventh Circuit Court of Appeals and that of the State officials charged with enforcement of the statute, violates fundamental rules of statutory construction and basic principles of federalism in contradiction of the clear direction of this Court in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989)?

2. Whether the Eighth Circuit misapplied this Court's instructions in *Planned Parenthood v. Casey*, 505 U.S. 83 (1992) by finding that a law banning cruel and unusual methods of killing a partially-born child is an "undue burden" on the right to abortion?

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE IN SUPPORT OF PETITIONER

The Rutherford Institute hereby respectfully moves the Court for leave to file the following brief *amicus curiae* in this case. The consent of counsel for the parties was requested and refused.

The Rutherford Institute is an international, non-profit civil liberties organization with offices in Charlottesville, Virginia and internationally. The Institute, founded in 1982 by its President, John W. Whitehead, educates and litigates on behalf of constitutional and civil liberties. Attorneys affiliated with the Institute have filed petitions for writ of *certiorari* in the United States Supreme Court in more than two dozen cases, and *certiorari* has been accepted in two seminal First Amendment cases, *Frazee v. Dept. of Employment Sec.*, 489 U.S. 829 (1989) and *Arkansas Educational Television Comm'n. v. Forbes*, 523 U.S. 666 (1998). Institute attorneys have filed over three dozen *amicus curiae* briefs in the United States Supreme Court, including *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989) and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). The Institute has published educational materials and taught continuing legal education classes in this area as well.[1]

The Rutherford Institute has as one of its purposes fostering respect for the uniqueness and paramount worth of human life. These values are deeply rooted in America's common law constitutional tradition and its morality and values. Diminishing the value and

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1 John W. Whitehead has published several books, numerous articles and two amicus briefs on abortion issues. *See, e.g.,. Webster v. Reproductive Health Services*, 492 U.S. 490 (1989) and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). The Institute also publishes informational pamphlets and briefs addressing abortion.

respect for life, including prenatal life, diminishes, in one form or another, the lives of all citizens. The Rutherford Institute believes that this case concerning the power of states to regulate abortion is important to constitutional jurisprudence and the growth and progress of the nation.

Beginning in 1985, *amicus curiae* undertook to extensively research the available medical and social literature to determine the extent to which the legalization of abortion had an adverse effect on the quality of life, the impact on the family, and its effect on health and social life. The relevant portions of that research are presented particularly as applied to the issue of partial birth abortion. The Rutherford Institute believes the expertise of its counsel will be of assistance to the Court in this case.

The Rutherford Institute is submitting a brief *amicus curiae* in support of the Petitioner. In light of the important issues being raised in this case, the Institute respectfully requests that its arguments be heard.

Respectfully submitted,

John W. Whitehead
Steven H. Aden
Maria E. Selig
THE RUTHERFORD INSTITUTE
1445 East Rio Road
Charlottesville, Virginia 22901
(804) 978-3888

Thomas W. Strahan
(Counsel of Record)
3740 Edmund Blvd.
Minneapolis, Minnesota
55406
(612) 729-6765

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TO THE HONORABLE CHIEF JUSTICE AND ASSOCIATE JUSTICES OF THE SUPREME COURT OF THE UNITED STATES:

STATEMENT OF *AMICUS CURIAE* INTEREST AND INTRODUCTION[2]

The Rutherford Institute is an international, non-profit civil liberties organization with offices in Charlottesville, Virginia and internationally. The Institute, founded in 1982 by its President, John W. Whitehead, educates and litigates on behalf of constitutional and civil liberties. Attorneys affiliated with the Institute have filed petitions for writ of *certiorari* in the United States Supreme Court in more than two dozen cases, and *certiorari* has been accepted in two seminal First Amendment cases, *Frazee v. Dept. of Employment Sec.*, 489 U.S. 829 (1989) and *Arkansas Educational Television Comm'n. v. Forbes*, 523 U.S. 666 (1998). Institute attorneys have filed over three dozen *amicus curiae* briefs in the United States Supreme Court, including *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989) and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). The Institute has published educational materials and taught continuing legal education classes in this area as well.

One of the purposes of The Rutherford Institute is to foster respect for the uniqueness and paramount worth of human life. These values are deeply rooted in America's common law constitutional tradition and its morality and values. Diminishing the value and respect for life, including prenatal life, diminishes, in one form or another, the lives of all citizens. The Rutherford Institute believes that this case concerning the power of states to regulate abortion is

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2 *Amicus curiae* The Rutherford Institute files this brief on Motion to the Court for leave to do so. Consent of counsel for the parties was sought and refused. Counsel for The Rutherford Institute authored this brief in its entirety. No person or entity, other than the Institute, its supporters, or its counsel, made a monetary contribution to the preparation or submission of this brief.

important to constitutional jurisprudence and the growth and progress of the nation.

Beginning in 1985, *amicus curiae* undertook to extensively research the available medical and social literature to determine the extent to which the legalization of abortion had an adverse effect on the quality of life, the impact on the family, and its effect on health and social life. The relevant portions of that research are presented particularly as applied to the issue of partial birth abortion. The Rutherford Institute believes the expertise of its counsel will be of assistance to the Court in this case.

SUMMARY OF ARGUMENTS

There is a public interest as well as a state interest in legislating against immoral acts and recognizing the moral status of the unborn child. Recognition of moral status does not require that legal personhood be established. It is sufficient if the existence of a living entity is recognized and that unjust or immoral acts may be committed against this entity. To a significant degree, the moral status or the social standing of the unborn becomes obvious when viewed in light of the moral outrage exhibited when Nebraskans learned of the cruel manner of the destruction by partial birth abortion. Moral status requires that the existence of actual life be acknowledged, not simply "potential life." Nor can the perceived therapeutic needs of others relegate the unborn child to a non-entity.

In the state of Nebraska, animals are protected from cruelty. The manner of the death of an animal is also regulated by the state. No one claims that an animal is a person or a human being. In addition to the enactment prohibiting partial birth abortion, the state legislature of Nebraska, by specific legislative findings and declared legislative purpose, has deplored the destruction of unborn human lives. However, the courts below have failed to take into account these legislatively mandated and constitutionally acceptable purposes.

Nebraska also has an interest in the moral status of the unborn

child because pregnant women who seek partial birth abortions do not protect this interest. These women are impaired in their decision-making because of a manipulation of their thought process prior to undergoing partial birth abortion. Most importantly, women are not given accurate information about the specific nature of the partial birth abortion prior to undergoing the procedure. Women who are likely to undergo a partial birth abortion are a special population who have been shown to have tendencies which increase the likelihood of undergoing this type of procedure. These tendencies include denial, low self-esteem and identity conflicts, immaturity, lack of social and economic resources as well as an inability to receive offers of assistance.

Most medical doctors and medical societies do not recognize the moral status of the unborn child. This occurs despite the fact that workers in abortion facilities frequently find that abortions at the late stage of pregnancy required for partial birth abortions are repugnant. In addition, doctors who perform partial birth abortions are well compensated for their services and may act as no more than a technician without consideration of the moral status of the unborn child. Similarly, medical societies, although recognizing the fetus as a patient for some purposes, abandon the unborn child to the claims of the pregnant woman.

ARGUMENT

I. There Is an Important Public and State Interest in the Moral Status of the Unborn Child as Intended by the Nebraska Law Banning Partial Birth Abortions.

A. The Unborn Child Is Entitled to a Recognized Moral Status.

Recognizing the moral status of the unborn child in the context of partial birth abortion does not require that legal personhood be established. What constitutes moral status is:

(1) the recognition that there is the existence of a living entity, and
(2) immoral or unjust acts may be committed against this living entity.

Status refers to a condition or social standing. To a significant degree, moral status or social standing has been bestowed upon unborn children by those who were morally outraged when they learned of the cruel manner of their destruction by the partial birth abortion procedure. Public officials used a variety of words or phrases to describe their feelings about partial birth abortion including "barbaric", "shocks the conscience" or "unfit for a civil society."[3] Public opinion polls have found that a substantial majority of those polled were opposed to partial birth abortion, and 30 states have passed legislation to ban the practice, frequently by large margins. Yet many of the laws were enjoined by the courts, including the Nebraska ban on partial birth abortion.

B. Unborn Children Are Not "Potential Life" Subject to the "Therapeutic" Considerations of

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3 Repugnance for abortion has been advanced as a possible intuitive response to resolution of the polarization over abortion. The reason is because it was observed that abortion protesters frequently carried signs showing abortions in later stages of pregnancy. Also, repugnance for abortion at later stages is frequently found among abortion facility personnel. *See, e.g.* Kaltreider, Goldsmith & Margolis, *The Impact of Mid Trimester Abortion Techniques on Patients and Staff*, 135 Am. J. Obstet. Gynecol. 235 (1979), Hern, *What about us? Staff Reactions to D & E*, 15 Adv. Planned Parenthood 3 (1980). Repugnance may be rooted in an empathic kinship with one another that is the source of what is precious and caring in human relationships when it is present - and all that is horrible and brutal when it is absent. Judges, *Hard Choices, Lost Voices. How the Abortion Conflict Has Divided America, Distorted Constitutional Rights, and Damaged the Courts*, 287 (1993).

Others.

In *Planned Parenthood v. Casey*, 505 U.S. 833, 876 (1992) the plurality opinion stated that the "state has a substantial interest in potential life." It is clear that actual life is being destroyed when arms are moving and feet are kicking as the unborn child is being killed in the partial birth abortion process. If one has only a potential life, it becomes virtually impossible to determine what obligations there might be to this potential life because these obligations only exist in the future. How can one be cruel, kind, just or unjust, protective or destructive to someone or some thing with such a vague, amorphous status?

The paramount emphasis on "therapeutic" abortion for the perceived benefit of the pregnant woman also plays an important role in denying the moral status of the unborn child. Sociologist Christopher Lasch has noted, "The contemporary climate is therapeutic, not religious. People today hunger not for personal salvation.. . but for the feeling, the momentary illusion of personal well-being, health,[4] and psychic security." Lasch, *The Culture of Narcissism* (1979). Terms such as free will, guilt, good and evil have no place in the therapeutic model. Kittrie, *The Right to Be Different, Characteristics of the Therapeutic State*, 39 (1971). In the therapeutic model, people are diseased, ill, or socially maladjusted, or perhaps immature, unbalanced or stressed. In the therapeutic model it is the doctor or scientist or therapist who is presumed to know what is best. One author calls it "therapeutic relentlessness." Hamburger,

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4 An editorial in the American Journal of Public Health, although acknowledging that morality and other values may come into play to a limited degree, said that health professionals are obligated to put health first, to do so by respecting the best available scientific evidence, and to be frank when putting aside evidence of other considerations, be they moral, religious, economic, or simple expedience. Susser, *Induced Abortion and Health as a Value*, 82 American Journal of Public Health 1323 (1992).

The Power and the Frailty: The Future of Medicine and the Future of Man, 83 (1973).

Another refers to this therapeutic model as a "modern form of torture, combining benevolence, indifference, and technological wizardry." Starr, *The Social Transformation of American Medicine*, 390 (1982). There is no place in the therapeutic model for any entity with moral status - least of all an unborn child.

C. Animals Are Protected from Cruelty in the Manner of Their Death.

In Nebraska, animals have more status than unborn children. No one claims these animals are persons or human beings. Animals are protected from cruel and inhumane treatment under existing Nebraska law prohibiting cruelty to animals. *See* Section 28-1008 through §28-1016, Rev. Stat. Neb., Reissue of 1995. Under the definition of terms section of that statute, cruelly mistreating means to knowingly and intentionally kill, maim, disfigure, torture, beat, mutilate, burn, scald, or otherwise inflict harm upon any animal. (Section 28-1008 (3)). Violations of the law are criminal acts. (Section 28-1009). Further, the law prohibiting cruelty to animals also regulates the manner of death of an animal. (Section 28-1008 (5)). If the state of Nebraska has the power to prevent cruelty to animals, including the manner of death, it certainly has the power to enact a law regulating the manner of death of unborn children, especially where the prohibited technique involves a particularly gruesome method of abortion.

D. The Opinion of the Federal District Court Sets Forth a Form of Killing Using the Partial Birth Abortion Method Which Is Within the Power of the State to Prohibit.

The partial birth abortion procedure or intact D & E or D & X described in the Federal District Court opinion in *Carhart v. Stenberg*, 972 F.Supp 507 (D.Neb 1997) sets forth a form of killing

performed in a clinical setting. According to the opinion, these killings are attempted or completed after the 15th week of gestation and not later than the 20th week of gestation. The procedure includes draining the amniotic fluid before beginning the evacuation procedure. The Respondent then attempts to grasp and divide the umbilical cord of the fetus, which transports arterial and venous blood between the fetus and the placenta. If he divides the cord, the fetus will usually die within 6 to 10 minutes. If he succeeds in dividing the umbilical cord, he does not wait for fetal death to occur before continuing the procedure.

When the fetus is presented feet first, the Respondent uses forceps to pull the feet of the living fetus from the uterus into the vaginal canal. He then pulls the remainder of the fetus, except the head, into the vaginal cavity to a point where the base of the fetal skull is lodged in the uterine side of the cervical canal. At that point, the size of the head will not permit him to pull it through the cervical canal into the vaginal cavity. To decompress the fetal skull and evacuate the contents in order to pull it through the cervical canal, the Respondent uses an instrument to either tear or perforate the skull to allow insertion of a cannula and removal of the brain and cranial fluid and tissue. If more convenient, he will crush the skull rather than pierce it in order to reduce the size of the skull. Brain death occurs sometime during this two to three second "reduction" procedure, but fetal heart function may continue for several minutes after the fetus's skull is decompressed. *Id.* at 514. Respondent testified that, in 1996, he removed approximately 20 fetuses completely intact and alive. The record indicates that this act was done deliberately and intentionally to cause the death of the fetus. This behavior is within the power of the state to regulate.

E. The Courts below Have Failed to Follow Established Principals of Decision-making and Recognize and Defer to Legislatively Mandated Purposes When They Relate to Abortion.

The state legislature of Nebraska has deplored the destruction

of unborn human lives by specific legislative findings and legislative declaration of purpose. Section 28-325. These legislative purposes specifically recognize and protect life in the womb and have been recognized by the state courts. In *Damos v. St. Pierre*, 402 So.2d 633 (La. 1981), parents were allowed to recover damages for a pre-natal injury to a fetus subsequently born dead. The court relied upon language in a statement of legislative purpose which stated that a person includes a human being from the moment of conception. In *Connor v. Monkem Co, Inc.*, 898 S.W.2d 89 (Mo. 1995), the Missouri Supreme Court held that non-viable unborn children may have wrongful death claims based on a legislative purpose which stated that legally protectable rights, privileges and immunities exist at the time of conception.

In other cases, state courts have recognized a cause of action for the wrongful death of unborn children based upon specific language in a wrongful death statute. In *Wiesrma v. Maple Leaf Farms*, 543 N.W.2d 787 (S.D. 1996), a non-viable fetus died after the mother contracted salmonella from the defendants. In interpreting a wrongful death statute that authorized a cause of action for the "death or injury of a person, including an unborn child," the South Dakota Supreme Court held that this applied to non-viable fetuses. In *Seef v. Sutkus*, 583 N.E. 2d 510 (Ill. 1991), an Illinois court recognized a fetus as a person under the state's wrongful death statute, which stated that the state of gestation of a human being shall not foreclose a cause of action. In Georgia, the crime of feticide was defined as the willful killing of a "quick" (or living) unborn child. A suit by the mother against the defendant for the homicide of an unborn child who was "quick" was allowed. *Porter v. Lassiter*, 87 S.E.2nd 100, (Ga. App. 1955). And in *Farley v. Sartin*, 466 S.E. 2d 522 (W. Va. 1995), a fetus of 18-22 weeks gestation had died in an automobile accident. The court held that the viability of a fetus was no longer a requirement for the wrongful death of a fetus. The court concluded there was no rational reason not to include non-viable fetuses, especially in light of statutory language that the wrongful death statute should be liberally construed.

In contrast, where there has been no legislative language specifically recognizing liability for the wrongful death of an unborn child, courts have refused to do so without such inclusive language. In *Humes v. Clinton*, 792 P.2d 1032 (Kan. 1990), a suit was brought by the parents for the wrongful death of a fetus after the mother underwent a therapeutic abortion after complications due to the use of an IUD. The court dismissed the wrongful death suit stating that if such a cause of action was to be created, it must be done by the legislature. Again, *Giardina v. Bennett*, 545 A.2d 139 (N.J. 1988), the court narrowly interpreted the word "person" as not to include an unborn child. They held that the cause of action for wrongful death was the creature of statute, and since the legislature had not adopted specific language to include unborn children, there was no cause of action. In *Thilbert v. Milka*, 646 N.E.2d 1025 (Mass. 1995), a Massachusetts court refused to extend wrongful death protection to a 16 week old fetus where the fetus was stillborn and held that any extension of liability was properly left to the legislature.

Since the Nebraska legislature has recognized unborn children as alive and human, recognition of the moral status of the unborn child and the granting of protection from being killed by means of partial birth abortion will, at least to a limited degree, carry out the legislatively mandated enactments of the state.

F. States May Legislate Against Immoral Acts.

The practice of partial birth abortion is immoral, and states have a legitimate interest in prohibiting conduct deemed immoral. *Bowers v. Hardwick*, 478 U.S. 186, 196 (1986) (upholding a Georgia sodomy law in part because it was rationally related to "the presumed belief of a majority of the electorate in Georgia that homosexual sodomy is immoral and unacceptable."). States can also make immoral conduct a crime. *Milner v. Apfel*, 148 F3d. 812, 814 (7th Cir 1998) (stating that a traditional purpose of criminal punishment is to express moral condemnation of the criminal's acts.)

The federal district court in *Planned Parenthood of Wisconsin*

v. Doyle II., 44 F.Supp.2d 975, 983 (W.D. Wis. 1999) specifically held that the state of Wisconsin had a legitimate state interest in morality as applied to the D & X procedure. It stated:

> at the point that the child is just inches from being born the state has sufficient interest to regulate the manner of the child's death, regardless of whether the state is able to keep the child alive. Wisconsin has declared that such children are not to endure - and Wisconsin physicians are not to inflict - the gruesome death imposed in the D & X procedure ... because it is apparently beyond Wisconsin's power to eliminate ... other methods of abortion Wisconsin can eliminate this one method.

In *Planned Parenthood of Wisconsin v. Doyle I.*, 162 F.3d 463,477-479 (7th Cir 1998), Manion, J., dissenting, stated that "there is a legitimate moral interest in banning the D & X procedure, and that the state's interests in potential life, in regulating the practice of medicine, and in the moral underpinnings of state law are legitimate." All these state interests form a solid basis for the state enacting a law to ban D & X abortions. Although Judge Manion acknowledged that the law may not save any lives, he noted that, "these laws have certainly elevated the public's concern over the fate of the potential human lives that are exposed to abortion." *Id.* at 479.

II. The State Has an Interest in the Moral Status of the Unborn Child Because Pregnant Women Who Have Partial Birth Abortions Do Not Protect this Interest.

A. Pregnant Women Who Seek Partial Birth Abortions Are Impaired in Their Decision-making Because of the Manipulation of Their Mental and Emotional State and Their Lack of Informed Consent.

Late term, mechanically induced abortion procedures such as dilatation and extraction (D & E) or partial birth abortion depend on a state of denial by the woman at the time the abortion is performed.

This is accomplished by administration of general anesthesia or sedation[5] to the woman to insure that she does not know or see exactly what is occurring. According to the AMA report, D & E procedures in the mid to late second trimester usually are performed with local anesthesia, using sedation and a paracervical block. *Carhart v. Stenberg*, 972 F. Supp. 507 at 512. The sedation, in particular, alters the thought processes of the woman to the point where she would cannot accurately perceive what is occurring[6] and cannot scream out in protest or come to the aid of the unborn child whose life is about to be destroyed if she wished to do so. Once her consciousness is altered, it is the medical doctor who is in control. Since she does not see what is occurring, she will, of necessity, have

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5 The partial birth abortion procedure developed by Martin Haskell utilized nitrous-oxide/oxygen administered nasally as an adjunt to local anesthesia. Haskell, *Dilation and Extraction for Late Second Trimester Abortion*. Presented at the National Abortion Federation F&k Management Seminar: Dallas, Texas, September 13, 1992; *see also* Coreen Costello, *Giving Up My Baby*, New York Times Op-Ed, November 23, 1995. A24 where woman was under anesthesia at the time of her partial birth abortion.

6 Examples of the altering of consciousness include using light anesthesia for the actual D & E procedure so the woman has little sense of what is going on as the fetus is dismembered inside her and pulled out with the forceps. Or as another woman put it, " Fifteen minutes or so of Demerol-induced oblivion and that's it." Abbott, *The Abortionist as Craftsman*, 22 Human Life Review 23 (1996). Although denial may occur at the time of the abortion and last for a period of time, it eventually breaks down and women may express a high level of stress from the experience. Among the long term stresses women experienced from D & E abortions, were anxiety regarding pain the fetus may have experienced, and guilt over the knowledge that a second or third trimester fetus had been dismembered. Speckhard, *Psycho-Social Stress Following Abortion*, 79-80 (1987).

to rely on the representations of the doctor.

A study of 250 women at the University of California, San Francisco during the 1970's is a case in point. In this study, women who had undergone mid-second trimester abortions by dilation and extraction under general anesthesia were interviewed three weeks post-abortion. D & E was seen as helpful in getting through an ambivalent situation and as tending to reinforce preexisting denial. The use of general anesthesia led to an experience which was described by the women as "like a dream" and "out of my hands." The researchers found that the D & E patient was consciously aware of avoiding the implications of the procedure and rarely asked any questions. Kaltreider, Goldsmith & Margolis, *The Impact of Mid Trimester Abortion Techniques on Patients and Staff*, 135 Am. J. Obstet. Gynecol. 235 (1979).

This approach violates the standards of the National Abortion Federation. These standards include "Objectives of Decision Counseling" which require that "accurate information" be provided so that "she retains her autonomy and control." These standards further provide, under "Objectives of Informed Consent," that the woman be provided with "accurate information, directly applicable to her procedure, about the risks of surgery, and the benefits of that surgery." In addition, the standards require that the abortion procedure be described "to the patient in terms she can readily understand." *Standards For Abortion Care*, National Abortion Federation 4 (1986). The standards do not provide for any "therapeutic" exceptions. The U.S. Supreme Court in upholding a state statute requiring informed consent prior to abortion stated, "The decision to abort is important and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences." *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976).

B. Pregnant Women Who Are Likely to Seek Partial Birth Abortions Are a Special Population with Significant Disadvantages

Which Increase the Likelihood of Partial Birth Abortion.

i. Characteristics of the Special Population.

The gestational age that the Respondent testified that he intends and prefers to use the intact D & E procedure on is "over 15 weeks." *Carhart v. Stenberg*, 972 F. Supp. 507 at 523. This gestational age for abortion represents a very small percentage of the total number of induced abortions performed in the United States each year. According to the Centers for Disease Control, only 5.8% of the 1,221,585 induced abortions reported in 1996 were performed at 16 weeks of gestation or more. Koonin and Associates, *Abortion Surveillance-United States*, 1996, 48 MMWR No. SS-4, July 30, 1999.

Women who obtain these later abortions are a special population. According to a 1987 survey by the Alan Guttmacher Institute of 420 women seeking abortions at 16 gestational weeks or more at various abortion facilities throughout the United States, they are significantly more likely to be teenagers under the age of 18,[7] black women,[8] unemployed women, women covered by Medicaid,

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7 The National Center for Health Statistics reported detailed abortions statistics for a 14 state area in 1988. Among women under 14 years of age, 14.6% had abortions at 16 gestational weeks or more compared to 13.3% of women age 14, 10.1% of women age 15, 9.2% of women age 16, 7.5% of women age 17, 4.9% of women age 20-24 years, and 3.9% of women age 25-29 years. National Center for Health Statistics, 39 (12) Monthly Vital Statistics Report, Supplement April 30, 1991, Table 10, 11.

8 The National Center for Health Statistics in a 14 state area in 1988, reported that 7.2% of black women had abortions at 16 gestational weeks or later compared to 3.9% of white women. National Center for Health Statistics, 39 (12) Monthly Vital Statistics

women fearing possible fetal health problems, women whose parents wanted them to have an abortion, or women whose pregnancy resulted from rape or incest. Women were significantly less likely to have a later abortion if they were age 30 or older, if they had no religious affiliation, if they were having health problems, or if their husband or partner wanted them to have an abortion. Torres and Forrest, *Why Do Women Have Abortions?*, 20 Family Planning Perspectives 169 (1988) (hereafter called the AGI Survey).

ii. Moral Conflicts.

A substantial number of the women who obtain abortions at 16 gestational weeks or later would be opposed to abortion on moral grounds. This would include religious women, black women and women of low income. A 1981 nationwide poll commissioned by the Connecticut Mutual Life Insurance Company asked, "Do you believe abortion is morally wrong, or is it not a moral issue?" Overall, 67% of females compared to 64% of males believed it was morally wrong. Among those with the lowest religious commitment, only 43% thought it was morally wrong compared to 75% with moderate religious commitment or 85% among those with the highest religious commitment. Blacks were more likely than whites to believe abortion is morally wrong (73% v. 64%). Among those with incomes under $12,000, 74% believed abortion was morally wrong compared to only 56% among those with incomes above $25,000. *The Connecticut Mutual Life Report on American Values in the 80s: The Impact of Belief*, 92 (1981). Some women with moral objections to abortion will still have an induced abortion but it will more likely be a late abortion compared to an early abortion. These moral conflicts include opposition of the woman to abortion and conflicted decisions. Burr and Schulz, *Delayed Abortion in an Area of Easy Accessibility*, 244 JAMA 44 (1980).

iii. Attachment to the Unborn Child.

Report, Supplement, April 30, 1991, Table 10,11.

Women who have abortions in the second trimester are also more likely to use the word "baby " in describing what is in her womb compared to women who have abortions in the first trimester, who are more likely to use words such as "this pregnancy" or "this condition." Kaltreider, *Emotional Patterns Related to Delay in Decision to Seek Legal Abortion*, 118 Calif. Med. 23 (1973). Another study found that pregnant women at more than 16 weeks gestation were much more likely to carry to term if they requested and were denied an abortion compared to women who were 16 weeks gestation or less. Binkin and Associates, *Women Refused Second-Trimester Abortion: Correlates of Pregnancy Outcome*, 145 Am. J. Obstet. Gynecol. 279 (1983).

iv. Indecision and Ambivalence.

Various studies have found that women who obtain abortions in the second trimester have significantly different behavior patterns compared to women obtaining abortions in the first trimester. High levels of indecision and ambivalence have been found in women undergoing mid trimester abortions compared to women having first trimester abortions. Osofsky and Associates, *Psychosocial Aspects of Abortion in the United States*, 42 Mt. Sinai Medical Journal 456 (1975). Researchers at the University of California concluded that "women who delay the decision to abort have a background of greater psychopathology and have difficulty in decision making. They often lack social supports and have difficulty with contraception." Kaltreider, Goldsmith and Margolis, *The Impact of Mid Trimester Abortions of Patients and Staff*, 135 Am. J. Obstet. Gynecol. 235 (1979). Researchers at the Yale University School of Medicine found that those who delayed seeking abortion until the second trimester frequently kept news of the pregnancy from partner and parents, and did not obtain financial help or refused it when offered. They also found that those who waited until the second trimester were often ambivalent about seeking the abortion and, to a lesser degree, were unwilling to accept the possibility of pregnancy. Bracken and Kasl, *Delay in Seeking Induced Abortion: A Review and Theoretical Analysis*, 121 Am. J. Obstet. Gynecol. 1008 (1975).

v. Immaturity.

Psychological immaturity was identified as one of the important factors resulting in delayed abortion in a Washington, D.C. study of 1066 women using multiple regression analysis. Burr and Schulz, (1980). The 1987 Alan Guttmacher Institute survey also found that women under the age of 18 are significantly more likely to obtain abortions at 16 gestational weeks or later compared to women who obtained abortions in the first trimester.[9]

vi. Biological Factors.

A history of irregular periods was found to be the strongest single predictor for women seeking a late abortion in a multiple regression study of Washington, D.C. women, although much of the variation in gestational age was not explained by the analysis.[10] Not knowing soon enough the gestational age of their pregnancy has also been found to be an important factor among women obtaining abortions at 16 weeks gestation or more.[11]

vii. Secrecy and Isolation.

According to a 1987 Alan Guttmacher Institute survey, almost two-thirds (63%) of U.S. women who have abortions as teenagers at 16 weeks gestation or more (and one-third of the overall sample) attributed the delay to being afraid to tell their partner or parent that they were pregnant.[12] Another study of post-abortion women, where women had frequently had second trimester abortions at a young age,

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9 Torres and Forrest (1988)

10 Burr and Schulz (1980)

11 Torres and Forrest (1988)

12 Torres and Forrest (1988)

reported that a great portion of the women did not admit pregnancy until a pregnancy test could no longer be avoided without also jeopardizing their chances to obtain an abortion. Abortion was utilized as a strategy for coping with the pregnancy without ever fully admitting that the pregnancy existed. Speckhard, *Psycho-Social Stress Following Abortion*, 97-98 (1987).

viii. Low Self Esteem and Identity Conflicts.

Poor ego strength and low self-esteem were found among women undergoing second trimester abortions at a Planned Parenthood of San Francisco facility.[13] Another study of New York City women found that abortion at later gestational ages was significantly associated with a greater disturbance of the basic sense of self due to gender/sexual conflict and lower levels of internalized striving or ambition. Cancelmo and Associates, *Psychodynamic Aspects of Delayed Abortion Decisions*, 65 Br. J. Medical Psychology 333 (1992).

ix. Lack of Resources and an Inability to Receive or Accept Assistance.

The Alan Guttmacher 1987 survey of women who obtained abortions at 16 weeks gestation or later found that unemployed women and women receiving Medicaid were more likely to have later abortions compared to women who had first trimester abortions.[14] Researchers at the Yale University School of Medicine found that it was characteristic of women who delay abortions not to obtain financial help or to refuse it when offered.[15] Kaltreider and Colleagues found that women who obtained second trimester

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13 Kaltreider (1973)

14 Torres and Forrest (1988)

15 Bracken and Kasl (1975)

abortions often lacked social supports and spoke more often of assessing the resources available to help them keep a child compared to women with first trimester abortions.[16]

x. Non-Use of Contraceptives.

Researchers have found that women who obtain second trimester abortions do not use contraceptives or use contraceptives to a lesser degree compared to women obtaining first trimester abortions. Researchers at the Yale University School of Medicine concluded that "available studies suggest that unprotected coitus correlates with delay in seeking an abortion."[17] The Washington, D.C. study which used multiple regression analysis to determine what factors are related to the gestational stage at which women seek an abortion found that contraceptive use predisposed women to earlier abortions.[18]

xi. Influence by Doctors or Genetic Counselors.

Doctors and other professionals may encourage abortions if there is a possibility that the baby would be born with a handicap, and may reinforce the parent's fear that they may not be equal to the task if a handicapped child were born, and that a special needs child would be too great a financial burden. Vought, *Post-Abortion Trauma*, 61 (1991) (citing other authorities). Prenatal diagnosis can be very stressful. Moral, religious or philosophical concerns may predominate. Rice and Doherty, *Reflections on Prenatal Diagnosis: The Consumers Views*, 8 Social Work in Health Care 47 (1982). If there is a crisis, a minimal amount of effort by a counselor or doctor may be able to exert a maximum amount of leverage on the stressed

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16 Kaltreider (1973); Kaltreider, Goldsmith & Margolis (1979)

17 Bracken and Kasl (1975)

18 Burr and Schulz (1980)

individuals. Morley, *Theory of Crisis Intervention*, 21 Pastoral Psychology 203 (1970).

A 1987 Alan Guttmacher Institute survey of U.S. women who obtained abortions at 16 weeks gestation or more found that 2% did so because a fetal problem was diagnosed late in pregnancy.[19] There is evidence that the incidence of partial birth abortions for reason of fetal defects is much higher, at least for one doctor. In 1995, James McMahon reported on a series of 1362 intact D & E abortions done over a 13 year period of which approximately one-third were reported to have been done on the basis of serious indication of fetal defect. Haskel, Easterling & Lichtenberg, *Surgical Abortion After the First Trimester in A Clinicians Guide to Medical and Surgical Abortion*, Paul, Maureen, 135-137 (1999). Induced abortions for genetic reasons have a high incidence of severe adverse psychological reactions.[20]

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19 Torres and Forrest (1988)

20 *See* e.g. Furlong and Black, *Pregnancy Termination for Genetic Indications: The Impact on Families*, 10 Social Work in Health Care 17 (1964) (even very young children may show reactions from parents' distress and maternal absence); Kolker and Burke, *Grieving the Wanted Child: Ramifications of Abortion After Prenatal Diagnosis of Abnormality*, 14 Health Care for Women Int'l. 513 (1993) (there is little understanding and societal support for those who experience abortion because of fetal defect); Suslak, Scherer and Rodriguez, *A Support Group for Couples Who Have Terminated a Pregnancy After Prenatal Diagnosis*, 4 Journal of Genetic Counseling 169 (1995) (severe reactions to termination of pregnancy included loss of self-esteem, hindrance of socialization, guilt from having killed their baby, difficulty in returning to church, grief reactions. Couples referred to the loss of their "baby" rather than the loss of their "fetus"); Rayburn and Laferla, *Mid-Gestational Abortion for Medical or Genetic Indications*, 13 Clinics in Obstetrics and Gynecology 71 (1986) (the psychological difference between elective

III. The State Has an Interest in the Moral Status of the Unborn Child Because Neither Abortion Professionals Using the Partial Birth Abortion Method Nor Medical Societies Protect this Interest.

A. Moral Dilemmas of Abortion Facility Workers.

Although the woman does not witness the dismemberment of the unborn child or see the unborn child stabbed in the back of its head and the contents of its brains removed, the medical doctor sees exactly what occurs because he or she is performing the act. For this reason, some medical doctors will not perform such a procedure. In the University of California, San Francisco study , one doctor who did abortions by the intra-amnoitic injection of prostaglandin but would not perform D & E's said, "Killing a baby is not a way I want to think about myself." It was reported that two doctors who did all of the D & E's in the study supported each other and relied upon a strong sense of social conscience[21] founded upon the health and desires of the

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and medically indicated abortions is extreme. Women going through elective abortion will primarily feel relieved while in those for genetic or maternal abnormality, a grief response is to be expected). Mothers who have an abortion for a genetic abnormality are at higher risk of requiring prolonged psychiatric hospitalization in the next 12 months); Blumberg, Gofbus & Hanson, *The Psychological Sequelae of Abortion Performed for a Genetic Indication*, 122 Am. J. Obstet. Gynecol. 799 (1975) (a high incidence of depression and other severe reactions was found among both men and women as well as a threat to family integrity, where women had undergone abortions for a prenatal detection of a genetic defect in the fetus.)

21 Whether or not induced abortion advances the social and economic status of women is problematical. A study by researchers at Yale University School of Medicine found that women with repeat abortions were more likely to be divorced and more likely to be welfare recipients compared to women with a single abortion.

woman. They felt technically competent but had strong emotional reactions during or following the procedures and occasional disquieting dreams. Kaltreider, Goldsmith and Margolis, *The Impact of Mid Trimester Abortion Techniques on Patients and Staff*, 135 Am. J. Obstet. Gyneco. 1235 (1979). A small study examined the emotional reactions of abortion facility staff to D & E abortions up to 23 weeks. Reactions to the fetus ranged from purposely not looking at it, to shock, dismay, amazement, disgust, fear, and sadness. Attitudes toward the doctor included sympathy, wonder at how he could perform the D & E at all, and a desire to protect him from the trauma. Distancing, projection and rationalization were used by staff to handle the traumatic impact of the destructive part of the operation and the procedure was viewed as destructive and violent. Many reported serious emotional reactions that produced physiological symptoms, like sleep disturbances, effects on interpersonal relationships, and moral anguish. Hern, *What About Us? Staff Reactions to D & E*, 15 Advances in Planned Parenthood 3 (1980).

The partial birth abortion (or intact D & E) is similarly very troublesome and distressing. It was graphically described by Brenda Pratt Shafer, a nurse who worked for Martin Haskell in Dayton, Ohio (in September, 1993) in testimony before the House Judiciary Committee on March 21, 1996. She said, in relevant part:

Shepard and Bracken, *Contraception and Repeat Abortion*, 11 Journal of Social Science 289 (1979). Overall, 60% of U.S. women who have an abortion will repeat abortion by age of 30. Henshaw and Kost, *Abortion Patients in 194-1995: Characteristics and Contraceptive Use*, 28 Family Planning Perspectives 140 (1996). A long term study also found that women with an abortion history were more likely to exhibit multiple problem behavior, have lower occupational prestige, be similar in educational attainment and have only slightly higher personal income compared to women with no abortion history. Costa and Associates, *Psychosocial Correlates and Antecedents of Abortion: An Exploratory Study*, 9 Population and Environment 3 (1987).

The mother was 6 months pregnant, 26 1/2 weeks. A doctor told her that her baby had Down Syndrome, and she decided to have an abortion. She came in the first two days to have the laminaria inserted and changed, and she cried the whole time. On the third day she came in to receive the partial birth abortion (called D & X by Martin Haskell). Dr. Haskell brought in ultrasound in and hooked it up, so that he could see the baby. I could clearly see the baby's heartbeat on the ultrasound screen. Dr. Haskell went in with forceps and grabbed the baby's legs and pulled them down into the birth canal. Then he delivered the baby's body and arms-everything but the head. The doctor kept the baby's head just inside the uterus. The baby's little fingers were clasping and unclasping, and his feet were kicking. Then the doctor stuck the scissors through the back of his head, and the baby's arms jerked out in a flinch, a startle reaction, like a baby does when you throw him up in the air and he thinks he might fall. The doctor opened up the scissors, stuck a high-powered suction tube into the opening, and sucked the baby's brains out. Now the baby went completely limp. I was really completely unprepared for what I was seeing. I almost threw up as I watched the doctor do these things. Dr. Haskell delivered the baby's head. He cut the umbilical cord and delivered the placenta. He threw that baby in a pan along with the placenta and the instruments he used. I saw the baby move in the pan and I asked another nurse and she said it was just "reflexes."

The woman wanted to see her baby, so they cleaned the baby up and put it in a blanket and handed the baby to her. She cried the whole time. Looking down into the baby's face, she said, "Please forgive me. I am so sorry. I love you." I was crying, too. I couldn't take it. That baby boy had the most perfect angelic face you've ever seen. I was present in the room for two more such procedures that day, but I think I was really in shock. I tried to pretend that I was somewhere else, to not think about what was happening. I just couldn't wait to get out of there. And after I left that day, I never went

back. These last two procedures involved healthy mothers with healthy babies. I was very much affected by what I had seen.

Brenda Pratt Shafer, R.N., *Testimony before Subcommittee on the Constitution, House Judiciary Committee, March 21, 1996*, reprinted in 14 Issues in Law and Medicine 99-100 (1998).

James McMahon, one of the doctors who utilized the partial birth abortion procedure which he called intact D & E, expressed moral reservations about the procedure. He was quoted in the press as saying,

> I have two positions that may be internally inconsistent, and that's probably why I fight this all the time. I do have moral compunctions. And if I see a case that's later, like after 20 weeks where it frankly is a child to me. I really agonize over it because the potential is so imminently there. I think, 'Gee, it's too bad that this child couldn't be adopted.' On the other hand, I have another position, which I think is superior in the hierarchy of questions, and that is: 'Who owns the child?' It's got to be the mother.

Gianelli, *Shock-tactic Ads Target Late-term Abortion Procedure*, American Medical News, p. 21, July 5, 1993.

B. Medical Doctors Fail to Protect the Moral Status of the Unborn Child in the Partial Birth Abortion Context.

Medical doctors and other abortion facility personnel either refuse to perform late stage abortions by quitting, or they may attempt to seek out social support in order to permit themselves to do so, or repress their emotions in some manner in order to involve themselves in the procedure.

i. The Doctor as a Technician.

Despite his moral reservations, James McMahon appeared to have concentrated on the technical aspects of intact D & E abortions. In an interview in 1990 he was quoted as saying regarding abortion, "That's my specialty ... that's my expertise. That's my passion ... Frankly, I don't think I was any good at all until I had done 3000 or 4000." Abbott, *The Abortionist as Craftsman*, 22 Human Life Review 23 (1996). Adopting new technical approaches to solve problems may increase confidence, and relieve stress. Hern, *What About Us? Staff Reactions to D & E*, 15 Advances in Planned Parenthood 3 (1980), but the doctor who does so is likely to become no more than a technician.

If one concentrates their energies and passion to improving the technique of abortion as in the case of James McMahon, becoming technically proficient is done at the expense of human values. One of the values lost is the respect for the dignity of human life in the womb. The loss of important values is often overlooked because the implicit and largely unchallenged argument seems to be that if the procedure is carried out by a technological specialist (a physician) in accordance with recognized medical practice, there is no need to be concerned about the purpose of the operation. However, dominant themes of the technological world are in conflict with the moral world. Hunt, *Technological Themes in the Abortion Debate in When Life and Choice Collide*, Ed David Mall, 255-258 (1994). French philosopher and theologian, Jacques Ellul, has identified modern technique as a form of idolatry noting that "Technique worships nothing (and) respects nothing." Ellul, *The Technological Society*, 142 (1964). Thus, barbaric practices can enter a society and may go unchallenged.

ii. The Medical Profession Fails to Protect the Moral Status of the Unborn Child in the Context of Partial Birth Abortion.

The American College of Obstetricians and Gynecologists (ACOG) guidelines on ethical decision-making states,

> In the care of the obstetric patient, the traditional physician-patient relationship expands to include the fetus. The physician retains an obligation to respect the autonomy of the pregnant woman while promoting her medical well-being. In addition, the physician must assume an obligation of beneficence (promoting the well-being of others) toward a second patient, the fetus. The weight that this obligation is given in comparison with previously established obligations to the woman is central to many ethical dilemmas in the practice of obstetrics.

Ethical Decision-Making in Obstetrics and Gynecology, ACOG Technical Bulletin No. 136, November, 1989. However, in the situation where the woman undergoes an abortion, the obligation of the physician toward the fetus breaks down as the autonomy of the woman is considered paramount.

Therefore, neither the American Medical Association (AMA) nor the American College of Obstetricians and Gynecologists (ACOG) recognizes the fetus as a patient or recognizes the moral status of the fetus or child within the context of partial birth abortions (intact D & E). There is no condemnation of nor limitation on inhumane or cruel procedures which take place in intact D & E partial birth abortions. In 1996, ACOG convened a special panel to review the intact D & X procedure which resulted in an ACOG policy statement which declared that the select panel "could identify no circumstances under which this procedure would be the only option to save the life or preserve the health of the woman" and that "an intact D & X however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision." *ACOG Statement of Policy*, approved by the executive board January 12, 1997. No specific examples of circumstances were given when an intact D & X would be the most appropriate procedure.

Similarly, the American Medical Society has concluded that:

> according to the scientific literature, there does not appear to be any identified situation in which an intact D & X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D & X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

AMA Policy: Women Physicians and Women's Health Issues, "Late-Term Pregnancy Termination Techniques" (H-5.982) 1998.

The state can regulate the practice of medicine in the context of abortion. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992) (upholding state statute requiring doctor to offer woman materials on fetal development) or in the interest of prohibiting immoral conduct. *Planned Parenthood of Wisconsin v. Doyle*, 44 F. Supp. 2d 975 (W.D. Wis. 1999).

CONCLUSION

Daniel Callahan has observed that courts and legislatures are increasingly forced to play the mediator for blocks of interests with nothing in common and forced to do what in great part should be done by ingrained cultural values: provide a framework of morals and a common ethical core to govern humane societal relationships. He states "contemporary individualism not only dissolves all culture - and thus all limits to human behavior - but also mixed with radical technology, sets the stage for unprecedented barbarism." Callahan, *The Tyranny of Survival* (1973). Partial birth abortion is barbaric and the state of Nebraska has an interest in banning its practice on the basis that it is immoral and that Nebraska recognizes the moral status of the unborn child in this limited context.

For all of the compelling reasons set forth above, the judgment of the Court of Appeals should be reversed and the law permitted to go into effect.

Respectfully Submitted,

John W. Whitehead
Steven H. Aden
Maria E. Selig
THE RUTHERFORD INSTITUTE
1445 East Rio Road
Charlottesville, Virginia
22906
(804) 978-3888

Thomas W. Strahan
(Counsel of Record)
3740 Edmund Blvd.
Minneapolis, Minnesota
55406
(612) 729-6765